MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

DISCHARGE SUMMARY

Effective Date: September 1, 2002 **Policy #:** HI-04

I. PURPOSE: To provide guidelines for the completion of discharge summaries.

II. POLICY:

A. The discharge summary provides a synopsis of the patient's clinical history while in the hospital. The basis for the discharge summary is the patient's clinical assessments, treatment plan, progress notes, and treatment plan reviews.

B. A discharge summary is to be entered into the patient record within fifteen (15) days following discharge.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. The attending physician or a designee is responsible for completing the discharge summary.

V. PROCEDURE:

A. The discharge summary will be written by a member of the hospital's professional staff who is well acquainted with the patient's clinical course during the hospitalization. The summary has to be signed off by the attending psychiatrist.

B. The discharge summary will contain the following information:

1. Identifying Data – patient's name, hospital number, date of admission, and discharge date.

2. Brief Psychiatric History – includes reason for admission and pertinent history.

3. Significant medical and/or physical findings – from review of the physical evaluation done by the medical clinic.

4. Laboratory, X-ray and other consultation findings – results of any significant diagnostic tests or procedures should be listed here along with any pertinent consultation findings.

5. Course in the hospital and condition at discharge – include mental status at admission and at discharge, target symptoms, address treatment modalities utilized, response to treatment, adverse or unexpected results of treatment (such as medication side affects), special treatment procedures used (such as seclusion and restraint), patient's role in the treatment process, justification for discharge (typically no longer in need of inpatient level of care, no longer a danger to self or others, can be safely and effectively treated within the community, etc.)

6. Disposition and treatment recommendations – significant components of the discharge planning process, difference of opinion with community providers, any significant communications with providers, families, Tarasoff concerns (if used, specify who was contacted, list phone numbers/addresses, indicate what was said, or else indicate where in the record such information can be found – details are VERY IMPORTANT).

7. Legal status at discharge- voluntary, conditional release, time left on present commitment and other details regarding commitment or other legal matters that may be important.

8. Discharge Instructions

    a. Medications at discharge including days of medications provided.
    b. Restriction to physical activities.
    c. Dietary restrictions.
    d. Follow-up instructions to patient.
    e. Conditions of release (if not mentioned in legal section).

9. Final Diagnosis – using current DSM criteria/terminology; all five axes. For I and II axes, include codes; for axis V, use GAF as defined in DSM-IV manual. Including a GAF (highest level in past year) can be useful.

10. Signature and Date

VI. REFERENCES: Hospital Licensure Standard 482.61(e); JCAHO IM.7, IM.7.3

VII. COLLABORATED WITH: Medical Staff, Director of Information Resources, Social Work Discipline Chief

VIII. RESCISSIONS: #HI-04, *Discharge Summary* dated May 20, 2002; Policy # HI-04 *Discharge Summary* dated February 14, 2000; HOPP #HI-08-97-R, *Discharge Summary*, dated April 9, 1997.

IX. DISTRIBUTION: All hospital policy manuals.

X. REVIEW AND REISSUE DATE: September 2005

XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XII. ATTACHMENTS: None

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Ed Amberg	Date	Thomas Gray, MD	Date
Hospital Administrator		Medical Director	